Commonwealth of Virginia
Department of General Services
Division of Consolidated Laboratory Services
Richmond, Virginia

DCLS COVID-19 Submission Form

PATIENT INFORMATION			SUBMITTER INFORMATION	
Last Name:			Submitting Facility:	
First Name:	M.I.		Address:	
Birth Date: / /	☐ Male ☐ Female		City:	
Address:			State:	Submitter Zip code:
City:	State:	Zip code:	Phone:	
County:			Fax:	
MRN:	Patient ID:		Attending Clinician:	Clinician Zip code:
Client External ID (VDH/DCLS#):			Attending Clinician Phone:	
Race:	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino		Public Health Dept Contact:	
Phone:	Pregnant: ☐ Yes ☐ UNK ☐ No		Public Health Contact Phone:	

PATIENT MEDICAL HISTORY

Disease Suspected or Diagnosis: **COVID-19**

Reason for Test Request: ☐ *COVID-19 Contact/Suspected Carrier* ☐ *Surveillance* ☐ *Diagnosis* ☐ *Clearance/Release* ☐ *VDH Reportable Disease Compliance* ☐ *Reinfection* ☐ *PPS* ☐ *Community Testing Event (CTE)* ☐ *Other:*

Patient's First COVID Test? ☐ *Yes* ☐ *No* ☐ *UNK* | Patient Hospitalized? ☐ *Yes* ☐ *No* ☐ *UNK* | *In ICU?* ☐ *Yes* ☐ *No* ☐ *UNK*

Employed in Health? ☐ *Yes* ☐ *No* ☐ *UNK* | ** Resident in a congregate care setting?* ☐ *Yes* ☐ *No* ☐ *UNK*

Received COVID Vaccine? ☐ *Yes* ☐ *No* | Date of Last Vaccine: / / | Vaccine Maker: | Total # Doses Received:

Symptomatic? ☐ *Yes* ☐ *No* ☐ *UNK* | Date of Onset: / / | Deceased Date: / /

Signs/Symptoms: ☐ *Asymptomatic* ☐ *Body Aches* ☐ *Chills* ☐ *Cough* ☐ *Diarrhea* ☐ *Fever* ☐ *Headache* ☐ *Loss of Taste/Smell* ☐ *Malaise/Fatigue* ☐ *Myalgia* ☐ *Nasal Congestion* ☐ *Nausea* ☐ *Pneumonia* ☐ *Rash* ☐ *Runny Nose* ☐ *Shortness of Breath* ☐ *Sinus Congestion* ☐ *Sore Throat* ☐ *Vomiting* ☐ *Other:*

OUTBREAK INFORMATION

VDH Designated Outbreak #: | Site/Event Location:

Patient Role: ☐ *Healthcare Provider* ☐ *Healthcare Worker* ☐ *Staff* ☐ *Patient* ☐ *Resident* ☐ *Other:*

SPECIMEN COLLECTION INFORMATION

Date Collected: / / | Time of Collection: : *(military time)*

Specimen Source: ☐ *Nasopharyngeal Swab* ☐ *Oropharyngeal/Throat Swab* ☐ *Nose (Nasal Passage)* ☐ *Saliva* ☐ *Sputum* ☐ *Bronchial Wash* ☐ *BAL* ☐ *Blood* ☐ *Serum* ☐ *Tracheal Aspirate* ☐ *Other:*

ADDITIONAL INFORMATION	DCLS STATE LAB USE ONLY:
	Place DCLS Label in space provided.

****Congregate Care Setting*** represents any nursing homes, correctional or treatment facilities, group homes, homeless shelters, or similar setting.

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